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HOPE HOME HEALTH LLC	1401 S ARVILLE STREET SUITE G LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your agency June 24 - 25, 2008. The active census at the time of the survey was 61. 15 clinical records were reviewed. 5 home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the 60-day written summary ("clinical summary") provided to the physician met the regulatory definition of a summary for 2 of 4 sampled patients who were recertified (#3, #4). Findings include: Record Review Patient #3	G 145		

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G 145	Continued From page 1 Patient #3 was an 82 year-old female (admitted 2/11/08) with diagnoses including Congestive Heart Failure, Chronic Ischemic Heart Disease, Dementia with Behavior Disturbances and Osteoporosis. The clinical summary dated 4/11/08, described Patient #3's current condition. The summary lacked evidence of results of any treatments or teaching administered during the previous certification period. The clinical summary lacked any reference regarding the patient's progress toward or completion of previously set goals. Patient #4 Patient #4 was a 73 year-old male (admitted 2/11/08) with diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension and Atrial Fibrillation. The clinical summaries dated 4/11/08 and 6/9/08, described Patient #4's current condition. The summaries lacked evidence of results of any treatments or teaching administered during the previous certification periods. The clinical summaries lacked any reference regarding the patient's progress toward or completion of previously set goals.	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by:	G 158		

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Based on record review, the agency failed to ensure care was administered in accordance with the plan of care established by the physician for 6 of 15 sampled patients. (#3, #5, #9, #11, #13, #15).

Findings include:

Record Review

Patient #3

Patient #3 was an 82 year-old female, admitted on 2/11/08, with diagnoses including Congestive Heart Failure, Chronic Ischemic Heart Disease, Dementia with Behavior Disturbances and Osteoporosis.

A physician's order for the certification period 4/11/08 - 6/9/08, indicated, " . . . skilled nurse (SN) to ensure patient/caregiver performs regular toileting to promote normal bowel and bladder function . . . weigh patient every week . . ."

The record lacked evidence in the nursing notes regarding any teaching or evaluations of a regular toileting plan, and lacked records of weekly weights in Resident #3's home or in the chart.

Patient #9

Patient #9 was a 51 year-old male admitted on 4/24/08. The diagnoses were Osteomyelitis, Cellulitis, End Stage Renal Disease, and Hypertension.

Record Review

1. On 4/24/08, the skilled nurse identified the

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G 158	Continued From page 3 patient had a Groshong double lumen in the right arm. On 4/24/08, the physician's orders indicated: "Flush PICC (Peripherally Inserted Central Catheter) daily with Saline 5cc (cubic centimeters) each port. Patient may flush PICC line on non skilled visits." On 5/24/08 and 5/31/08, the licensed nurse documented: "PICC line is patent and flushed with normal saline 10cc to each lumen." The licensed nurse flushed the PICC line with 10cc normal saline, not 5cc as per the physician's order. 2. On 6/5/08, physician's orders indicated: " Zinc oxide around wound; Acticoat; Kerlix, ace wrap change dressing, i.e. (for example) gauze every 2 days. leave Acticoat intact." On 6/9/08, the licensed nurse documented: "Right leg 3 + edema. Wound care done , cleansed with wound cleanser and apply Silvasorb gel and covered with dry sterile dressing and secured with Kerlix and ace wrap. Patient instructed to elevate legs when resting. Continue with same wound treatment until Acticoat is available." There was no documented evidence to verify the previous wound care treatment was to be continued until the Acticoat was available. The physician's order indicated "leave Acticoat intact." On 6/11/08, the licensed nurse documented: Wound care continued with ___(unable to read) treatment. Cleansed with wound cleanser applied Silvasorb gel and covered with dry sterile dressing, secure with Kerlix and ace wrap."	G 158		

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G 158	Continued From page 4 On 6/12/08, the skilled nurse documented: "Wound care to right ankle. Cleansed with wound cleanser, applied Silvasorb gel and covered with dry sterile dressing. secured with Kerlix and ace wrap." The licensed nurse failed to follow the written plan of care established by the physician. Patient #15 Patient #15 was an 85 year-old female admitted on 2/2/08. The diagnoses were Neuralgia/Neuritis and Osteoarthrosis. Record Review The physician's orders dated 2/2/08, indicated, "Skilled Nurse visits: 1 time a week for 9 weeks and CNA (certified nursing aide): 1 time a week for 9 weeks." On 2/14/08, a physician's order indicated: "Extra visit for skilled nurse-son called patient has open area heel ___(unable to read) Patient wears boots (pressure both heels). Son wants a skilled nurse visit today for wound care with normal saline, pat dry with dry sterile dressing. " On 2/14/08 and 2/17/08, there was no documented evidence the skilled nurse treated the open area on the heel per the physician's order. Patient #11 Patient #11 was a 73 year-old male admitted on 5/13/08. The diagnoses were Paralysis Agitans, Abnormality of Gait, Hypertension, Venous	G 158		

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G 158	Continued From page 5 Thrombosis, and Cerebrovascular Accident. Record Review Physician's orders dated 5/13/08 through 7/11/08, indicated, "Physical Therapy Evaluation for strengthening exercises and gait training; Occupational Therapy Evaluation for functional mobility and upper extremity strengthening exercises." On 5/15/08, physician's orders indicated, "Physical Therapy visit 1 time a week for 1 week; 2 times a week for 5 weeks." There was no documented evidence to verify physical therapy visits were conducted during the week starting 6/8/08. Patient #5 Patient #5 was an 87 year-old female admitted on 5/28/08. The diagnoses were Urinary Tract Infection, Malaise and Fatigue, Dementia with Behavior Disturbance and Hypertension. Record Review Physician's orders dated 5/28/08 through 7/26/08, indicated, "Skilled Nurse visit 1 time a week for 9 weeks. Physical Therapy evaluation for strengthening exercise and gait training." On 6/11/08, a physician's order was obtained to provide certified nurse aide (CNA) services: 2 times a week for 1 week; 3 times a week for 6 weeks to assist with personal care. There was only one documented CNA visit during	G 158		

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G 158	Continued From page 6 the week of 6/11/08, instead of two as per physician's orders. Patient #13 Patient #13 was a 73 year-old male admitted on 4/29/08. The diagnoses were Diabetes Mellitus and Hypertension. Record Review The physician's orders dated 4/29/08 through 6/27/08, indicated, "Skilled Nurse visits: 1 time a week for 9 weeks + 2 PRN (as needed) for catheter problems. Skilled Nurse to change Foley Catheter French 18/10cc (cubic centimeters) times 1 month, leg bag and drainage bag, Irrigate Foley with 50cc Normal Sterile Saline PRN. Dietitian to assess and teach nutritional needs of patient." 1. On 5/13/08, the licensed nurse documented, "Catheter changed with #16 French catheter." The skilled nurse inserted a #16 French catheter, instead of a #18/10cc French catheter, as ordered. 2. There was no documented evidence to verify that the dietitian conducted an evaluation as per the physician's order.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any	G 159		

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G 159	Continued From page 7 safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, the agency failed to establish and provide instructions for timely discharge for 1 of 15 sampled patients (#4). Findings include: Patient #4 Patient #4 was a 74 year-old male (admitted 2/11/08) with diagnoses including Atrial Fibrillation, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Hypertension. Record Review The Plan of Care for 6/10/08 - 8/8/08 (the 3rd certification period) lacked instructions regarding discharge plans.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to alert the physician to changes in the patient's condition which suggested a need to alter the plan of care for 3 of 15 sampled patients (#1, #9, #15).	G 164		

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Findings include:

Patient #15

Patient #15 was an 85 year-old female admitted on 2/2/08. The diagnoses were Neuralgia/ Neuritis and Osteoarthrosis.

Record Review

Physician's orders dated 2/2/08, indicated, "Skilled Nurse visits: 1 time a week for 9 weeks and CNA (certified nursing aide): 1 time a week for 9 weeks. On 2/20/08, a physician's order was obtained for a skilled nurse to assess wound on the left little toe."

On 2/7/08, the licensed nurse documented: "has a skin tear to back of right leg area is 1cm (centimeter) by 1cm. Using universal precaution and aseptic technique. cleaned leg with normal saline. Area had been bleeding had a 4x4 saturated and dripping with blood. bleeding has stopped at this time. put non stick Telfa and bordered gauze on area. Instructed grandson to monitor area and what to do if bleeding continues."

On 2/10/08, the licensed nurse documented: "using universal precautions and aseptic technique cleaned wound on back of calf area 1cm x 1cm applied CDD (clean dry dressing)."

On 2/14/08, the licensed nurse documented: " In bed rails up. got call from grandson reports new wound on outer left pinkie toe area is discolored blue/black is 1 cm x 1cm no drainage noted. Using universal precautions and aseptic

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technique cleaned wound with normal saline patted dry and put CDD (clean dry dressing). Also cleaned area on back of right calf with normal saline patted dry and put CDD. Taught grandson what to watch for, for infection, redness, warmth and pain and call agency for help."

On 2/20/08, the licensed nurse documented: "using universal precautions and aseptic technique cleaned left outer pinkie toe with normal saline applied CDD (clean dry dressing)."

On 2/24/08, the licensed nurse documented: "using universal precautions and aseptic technique cleaned outer left little toe wound and right posterior calf."

On 3/5/08, the licensed nurse assessed, the wound on the right calf which measured 2cm x 3cm, Stage II with surrounding red skin with an appearance of the wound bed was black in color.

The licensed nurse failed to alert the physician of the skin tear on the right leg, the episode of bleeding of the leg, and the appearance of the wound located on the right calf. The licensed nurse conducted a visit on 2/20/08 per physician's order. The licensed nurse failed to alert the physician of the findings and obtain treatment orders for the new wound developed on the outer portion of the left pinkie toe.

Patient #9

Patient #9 was a 51 year-old male admitted on 4/24/08. The diagnoses were Osteomyelitis, Cellulitis, End Stage Renal Disease and Hypertension.

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G 164	Continued From page 10 Record Review On 6/5/08, physician's orders indicated, "Zinc oxide around wound; Acticoat; Kerlix, ace wrap change dressing ie. (example) gauze every 2 days. leave Acticoat intact." On 6/9/08, the licensed nurse documented: "Right leg 3 + edema. Wound care done , cleansed with wound cleanser and apply Silvasorb gel and covered with dry sterile dressing and secured with Kerlix and ace wrap. Patient instructed to elevate legs when resting. Continue with same wound treatment until Acticoat is available." There was no documented evidence to verify the physician was alerted that the Acticoat was not available, though the order indicated to leave Acticoat intact. Patient #1 Patient #1 was a 50 year-old female (admitted 4/23/08) with diagnoses including Syncope with Collapse, Central Hearing Loss and Constipation. Record Review A physician's order for the certification period 4/23/08 - 6/21/08 indicated, "Skilled nursing (SN) visits 1 time a week for 9 weeks." There was no evidence a SN visit was made the week of 4/27/08 or the week of 6/8/08. There was no evidence the physician was informed that no visit was conducted during the weeks of 4/27/08 and 6/8/08. Interview	G 164		

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G 164	Continued From page 11 On 6/24/08 in the afternoon, the Administrator indicated no SN notes were submitted for Patient #1 for the weeks of 4/27/08 and 6/8/08.	G 164		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the agency failed to ensure drugs and treatments were administered by staff only as ordered by the physician for 5 of 15 sampled patients (#1, #3, #9, #10, #15). Findings include: Patient #10 Patient #10 was a 74 year-old male (admitted 6/17/08) with diagnoses including Left Inguinal Hernia, Hypertension, and Status Post Hernia Repair on 6/16/08. Observation On 6/24/08 in the afternoon, the registered nurse (RN) removed the left inguinal surgical site dressing (applied by the physician earlier in the day) and cleansed the area with normal saline. The RN then applied a dry gauze dressing and secured it with tape. Record Review	G 165		

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The chart for Patient #10 had an order (dated 6/17/08) for the left inguinal post surgical wound to be "cleansed with normal saline, patted dry and kept open to air" (no frequency written).

There was no order to apply any kind of dressing to the incision.

Patient #1

Patient #1 was a 50 year-old female (admitted 4/23/08) with diagnoses including Syncope with Collapse, Central Hearing Loss, and Constipation.

Abbreviations:

BID = twice a day
cap = capsule
hs = hour of sleep
MAR = Medication Administration Record
MDI = metered dose inhaler
mEq = milli-equivalents
mg = milligrams
prn = as needed for
OTC = over the counter
po = by mouth
Q = every
QD = every day
QID = four times a day
tab = tablet
TID = three times a day

Interview

On 6/25/08 in the morning, Patient #1 explained she was taking Hydromorphone 4 mg 2 tabs po BID but since 6/3/08, she had been taking 10 mg po QID. Patient #1 indicated she had been taking

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Temazepam 30 mg po at hs since 6/9/08. Patient #1 indicated she had been taking Zyprexa 5 mg 1 tab po QD for awhile (start date unknown) and had increased the Zyprexa 5 mg to 2 tabs the morning of 6/25/08.

Record Review

A nursing note dated 5/7/08, indicated, " . . . taking Amitizia every day, no bowel movement for 3 days . . ."

The physician's order (for the certification period of 4/23/08 - 6/21/08) revealed Patient #1 was to take Hydromorphone 4 mg 12 tabs po QD. There was no order in Patient #1's chart for Temazepam, Zyprexa, Amitizia or the increased dosage of Hydromorphone.

Patient #3

Patient #3 was an 82 year-old female (admitted 2/11/08) with diagnoses including Congestive Heart Failure, Chronic Ischemic Heart Disease, Osteoporosis, and Dementia.

Interview

On 6/24/08 in the afternoon, the caregiver explained Patient #3 was taking Warfarin 4 mg po QD; Klor-Con 20 mEq 1/2 tab po QD; Seroquel 50 mg in the AM and Seroquel 100 mg in the PM.

Record Review

The physician's order (for the certification period 4/11/08 - 6/9/08) revealed Patient #3 was to take Klor-Con 20 mEq 1 tab po QD; Seroquel 100 mg 1 tab po Q AM and 100 mg 1/2 tab Q PM.

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G 165	Continued From page 14 The physician's orders for the certification period 4/11/08 - 6/09/08, read "Skilled nurse (SN) to ensure patient/caregiver. . . regular toileting to promote normal bowel and bladder function . . ." There was no evidence in any of the SN notes that Patient #3 or the caregiver was instructed regarding regular toileting. The Plan of Care for the certification period 6/10/08 - 8/8/08 (the third certification period) lacked the following medication change orders which occurred in the previous certification period: a) Seroquel 100 mg 1 tab po Q AM was changed to Seroquel 50 mg 1 tab po Q hs; b) Nexium 40 mg 1 tab po QD was added; c) Namenda 10 mg 1 tab po BID was added (all 3 changes as of 5/20/08); and d) Advair inhale 1 puff BID was added (date unknown). Patient #9 Patient #9 was a 51 year-old male admitted on 4/24/08. The diagnoses were Osteomyelitis, Cellulitis, End Stage Renal Disease, and Hypertension. The skilled nurse visits indicated, "3 times a week for 9 weeks. PICC (Peripherally Inserted Central Catheter) dressing change once a week. " Record Review On 4/28/08 and 5/5/08, the skilled nurse documented, "Aseptic technique ____(unable to read) Chloraprep used to clean PICC line site."	G 165		

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On 5/14/08, the skilled nurse documented, "PICC line dressing changed due to increase of crusted area on PICC line site. Aseptic technique observed. Patient tolerated procedure well."

On 5/21/08 and 6/2/08, the skilled nurse documented, "PICC line dressing changed cleansed with Chloraprep and covered with transparent dressing."

On 5/24/08, 5/26/08 and 5/31/08, the skilled nurse documented, "PICC line dressing changed."

There was no documented evidence to verify the skilled nurse clarified the specific treatment for the dressing change to the PICC line.

Patient #15

Patient #15 was an 85 year-old female admitted 2/2/08. The diagnoses were Neuralgia/Neuritis and Osteoarthrosis.

Record Review

The physician's order dated 2/2/08 through 4/1/08, indicated, "Skilled Nurse visits: 1 time a week for 9 weeks and CNA (certified nursing aide): 1 time a week for 9 weeks."

On 2/7/08, the licensed nurse documented, "has a skin tear to back of right leg area is 1cm (centimeter) by 1cm. Using universal precaution and aseptic technique. cleaned leg with normal saline. Area had been bleeding had a 4x4 saturated and dripping with blood. bleeding has stopped at this time. put non stick Telfa and bordered gauze on area. Instructed grandson to

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G 165	Continued From page 16 monitor area and what to do if bleeding continues." On 2/10/08, the licensed nurse documented, "using universal precautions and aseptic technique cleaned wound on back of calf area 1cm x 1cm applied CDD (clean dry dressing)." On 2/14/08, the licensed nurse documented, "In bed rails up. got call from grandson reports new wound on outer left pinkie toe area is discolored blue/black is 1 cm x 1cm no drainage noted. Using universal precautions and aseptic technique cleaned wound with normal saline patted dry and put CDD. Also cleaned area on back of right calf with normal saline patted dry and put CDD. Taught grandson what to watch for, for infection, redness, warmth and pain and call agency for help." On 2/20/08, a physician's order for an extra home visit was obtained to assess a wound on the left little toe - The son had called the office. On 2/20/08, the licensed nurse documented, "using universal precautions and aseptic technique cleaned left outer pinkie toe with normal saline applied CDD." There were no physician's orders obtained to treat the wound. On 2/24/08, the licensed nurse documented, "using universal precautions and aseptic technique cleaned outer left little toe wound and right posterior calf." There were no physician's orders obtained to treat the wounds.	G 165		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.	G 170		

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This STANDARD is not met as evidenced by:
Based on record review, the agency failed to provide care in accordance with the plan of care for 1 of 15 sampled patients (#4).

Findings include:

Patient #4

Patient #4 was a 73 year-old male (admitted 2/11/08) with diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, and Atrial Fibrillation. The patient resided in an adult group care facility with a caregiver on duty 24 hours a day, 7 days a week.

Record Review

The home health aide care plan dated 2/11/08, lacked an update/review for the certification periods of 4/11/08 - 6/9/08 or 6/10/08 - 8/8/08. The care plan revealed the home health aide was to do the following 2 times per week (each visit):

a) shampoo and comb the patient's hair;
b) check skin for pressure areas;
c) shave the patient's face; and
d) record the patient's last bowel movement

There was no documentation on the visit notes indicating the home health aide had:

a) shampooed and combed the patient's hair on 6/12/08;
b) checked the patient's skin for pressure areas on 5/9/08, 5/13/08, 5/15/08, 5/19/08, 5/21/08,

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G 170	Continued From page 18 5/26/08, 5/28/08, 6/3/08, 6/6/08, 6/9/08; c) shaved the patient's face on 5/9/08, 5/13/08, 5/15/08, 5/19/08, 5/21/08, 5/26/08, 5/28/08, 6/3/08, 6/6/08, 6/9/08, 6/12/08; and d) recorded the patient's last bowel movement on 5/15/08. The record lacked documentation indicating Patient #4 refused the services or any other explanation why the services had not been provided. The record lacked documentation indicating the home health aide contacted the skilled nurse regarding these services being refused and/or not being provided.	G 170		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure written instructions (Care Plan) were prepared for the home health aide by the registered nurse (RN) for 3 of 5 sampled patients who received home health aide services (#3, #4, #10). Findings include: Patient #3 Patient #3 was a 82 year-old female (admitted 2/11/08) with diagnoses including Congestive Heart Failure, Chronic Ischemic Heart Disease,	G 224		

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G 224	Continued From page 19 Hypertension, Osteoporosis, Dementia, and recently Pneumonia. Record Review Patient #3's home health aide care plan for the certification period 2/11/08 - 4/11/08 lacked a date in the recertification review section. Neither the RN nor the home health aide signed the care plan to indicate it had been reviewed and/or updated by the RN and acknowledged by the home health aide for the certification period of 4/11/08 - 6/9/08. Patient #4 Patient #4 was a 73 year-old male (admitted 2/11/08) with diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, and Atrial Fibrillation. Record Review The only home health aide care plan in the record was dated 2/11/08. There were no care plans prepared for the certification periods from 4/11/08 - 6/9/08 and 6/10/08 - 8/8/08. The original care plan lacked evidence of updates, revisions or any additional dates or signatures. Patient #10 Patient #10 was a 74 year-old male (admitted 6/17/08) with diagnoses including Left Inguinal Hernia, Hypertension, Status Post Hernia Repair on 6/16/08. Record Review	G 224		

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G 224	Continued From page 20 The record lacked evidence of a home health aide care plan and a home health aide visit note for 6/17/08. Interview On 6/25/08 in the morning, the Administrator acknowledged the home health aide saw Patient #10 on 6/17/08 without having a care plan to follow.	G 224		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse (RN) made an on-site visit to patients' homes no less frequently than every 2 weeks for 2 of 5 sampled patients who received home health aide services (#2, #4). Findings include: Patient #2 Patient #2 was a 62 year-old female admitted on 3/28/08. The diagnoses were Open Wound to Right Knee, Diabetes Mellitus, Atrial Fibrillation, Hypertension, and Chronic Obstructive Bronchitis. Record Review The physician's orders dated 3/28/08 through	G 229		

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G 229	Continued From page 21 5/26/08, indicated, "Skilled Nursing visits daily; CNA (certified nurse aide) visits 1 time a week for 1 week; 2 times a week for 8 weeks." There was only one supervisory visit which was documented by the RN on 4/30/08. Patient #4 Patient #4 was a 74 year-old male (admitted 2/11/08) with diagnoses including Atrial fibrillation, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, and Dementia. Record Review The chart contained two Supervisory Visit Reports dated 4/22/08 and 5/7/08. The following 11 items were to be answered "yes", "no" or "n/a". 1. CNA care plan current 2. CNA follows care plan as ordered 3. CNA care plan and care meet the patients need 4. Patient/caregiver know when CNA visits are going to be made 5. CNA is prompt or notifies patient/caregiver if delay occurs 6. CNA respects patient's privacy and confidentiality 7. CNA demonstrates proper body mechanics and universal precautions 8. CNA wears appropriate clothing 9. Patient's overall appearance reflects good personal care 10. Patient/family are satisfied with CNA services 11. Joint visit with CNA	G 229		

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G 229	Continued From page 22 There was no documentation in any of the columns indicating "yes", "no" or "n/a" for any of the 11 items. The area for patient/caregiver comments was blank on both forms. Both forms were signed by the RN and the home health aide and dated as noted above.	G 229		